Welborne, White & Schmidt
EXCELLENCE IN DENTISTRY

HIPAA AUTHORIZATION FORM

(Permission from patient/patient's legal guardian to share personal medical information)

PATIENT NAME: _____

DOB: _____/_____/_____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

I, _____, hereby authorize Welborne, White & Schmidt Dentistry to release any and all medical information such as treatment plans and financial arrangements that pertain to me, to the following individual(s):

Name: _____Phone #: _____ Relationship to pt. _____

Name: _____Phone #: _____ Relationship to pt. _____

Name: _____Phone #: _____ Relationship to pt. _____

_____ _____

Signature of Patient or Legal Guardian Date